REMARKS OF JIM GARDNER
CHIEF EXECUTIVE OFFICER
NORTHEAST GEORGIA HEALTH SYSTEM, INC.
AS PREPARED FOR DELIVERY TO
HOUSE COMMITTEE ON ENERGY AND COMMERCE
WASHINGTON, D.C.
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MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I'M HONORED TO BE WITH YOU TODAY. MY NAME IS JIM GARDNER AND I AM CHIEF EXECUTIVE OFFICER AT NORTHEAST GEORGIA MEDICAL CENTER AND HEALTH SYSTEM IN GAINESVILLE, GEORGIA, ABOUT AN HOUR NORTH OF ATLANTA. OUR HOSPITAL IS A 557-BED REGIONAL, NOT-FOR-PROFIT COMMUNITY HOSPITAL SERVING WELL OVER A HALF-MILLION PEOPLE IN NORTHEAST GEORGIA. OUR EMERGENCY ROOM TREATS CLOSE TO 100,000 PATIENTS A YEAR AND IS THE THIRD BUSIEST IN THE STATE OF GEORGIA.

MY CONGRESSMAN, CHAIRMAN NATHAN DEAL, ASKED ME TO SHARE WITH THIS COMMITTEE THE PERSPECTIVES OF A REAL-LIFE COMMUNITY HOSPITAL WORKING HARD TO SURVIVE IN THIS COUNTRY. WE ARE FACING CONSIDERABLE CHALLENGES – DEALING WITH INCREASES IN THE NUMBER OF UNINSURED PATIENTS AND POTENTIAL REDUCTIONS IN GOVERNMENT FUNDING FOR MEDICAID. I'M NOT SURE I CAN DO THAT ASSIGNMENT JUSTICE IN OUR SHORT TIME TOGETHER, BUT I WOULD LIKE TO OFFER A FEW THOUGHTS FOR YOUR CONSIDERATION.

LET ME BEGIN WITH MEDICAID. I DEEPLY RESPECT THE PRESSURE YOU AND YOUR COUNTERPARTS AT THE STATE LEVEL ARE UNDER TO REDUCE THE UNSUSTAINABLE RATE OF GROWTH IN THE MEDICAID PROGRAM. IN GEORGIA, MEDICAID ENROLLMENT HAS RISEN MORE THAN 50% IN FIVE YEARS AND GEORGIA HOSPITALS ARE PAID 13% LESS THAN THE ACTUAL COST OF CARE FOR EACH AND EVERY MEDICAID PATIENT WE TREAT. IN COMBINATION WITH RISING PRIVATE INSURANCE PREMIUMS (PARTLY DUE TO "COST SHIFTING") AND ILLEGAL IMMIGRATION RATES, GEORGIA'S ALREADY LIVING HEALTHCARE'S "PERFECT

STORM". THIS SAME SCENARIO IS BEING PLAYED OUT ALL OVER THE COUNTRY AND RESPECTFULLY DEMANDS A BIPARTISAN ACTION PLAN TO REDESIGN WHAT HAS EVOLVED INTO A FLAWED MEDICAID PROGRAM THAT THREATENS NOT ONLY HOSPITALS AND OTHER PROVIDERS, BUT ALSO THE COMMUNITIES AND THE PEOPLE YOU REPRESENT.

WITHOUT FUNDAMENTAL REFORM OF THE MEDICAID PROGRAM, THAT INCLUDES MEASURES TO PROTECT PROVIDERS, ESPECIALLY NON-PROFIT "SAFETY NET" COMMUNITY HOSPITALS LIKE NORTHEAST GEORGIA MEDICAL CENTER, FROM BEARING THE BURDEN OF SUCH REFORM, I AM CONFIDENT THAT RAPIDLY ESCALATING COSTS OF THIS INEFFICIENT PROGRAM WILL FORCE STATES TO CUT MORE PEOPLE FROM MEDICAID ROLLS. THIS WILL INCREASE THE NUMBER OF UNINSURED AND FURTHER WEAKEN THE HEALTH STATUS OF COMMUNITIES ACROSS THE NATION WHICH WILL DRIVE COSTS EVEN HIGHER, AND FORCE HOSPITALS TO IMPLEMENT SEVERE COST REDUCTIONS TO STAY SOLVENT.

IN THE CURRENT SYSTEM, PATIENTS ALL TOO FREQUENTLY ACCESS HEALTHCARE IN THE EMERGENCY ROOM, WHICH I'M SURE ALL OF YOU KNOW IS THE SINGLE MOST EXPENSIVE SETTING TO PROVIDE MEDICAL CARE. IN OUR COMMUNITY, A TYPICAL VISIT TO THE DOCTOR'S OFFICE COSTS ABOUT $74 – BUT THE COST IN THE ER IS MORE THAN THREE AND ONE-HALF (3.5X) TIMES THAT AMOUNT. DUE TO FEDERAL EMTALA REGULATIONS, HOWEVER, MY HOSPITAL HAS NO CHOICE BUT TO SERVE AS THE COMMUNITY "SAFETY NET". IN 2004 OUR HEALTH SYSTEM TREATED OVER 20,000 UNINSURED EMERGENCY ROOM PATIENTS AT A COST OF $6.9 MILLION. IN THE LAST FIVE YEARS OUR COMBINED BAD DEBT, INDIGENT CARE AND CHARITY CARE COST HAS MORE THAN DOUBLED HOSPITAL-WIDE, FROM $16.6 MILLION IN 2000 TO MORE THAN $35 MILLION THIS YEAR. TO REINFORCE THIS POINT – I STRESS THESE ARE MY COSTS – NOT CHARGES.

A full 29% of the patients presenting to the ER in 2004 were non-emergent, and seeking basic healthcare for common maladies like ear infections and the flu. Just extrapolating our numbers, that's roughly 29,000 patients and $5.6m dollars needlessly wasted in one ER. That $5.6m would buy an additional 75,000 physician office visits. With proper incentives 104,000 patient visits could have been provided in Gainesville instead of just 29,000 with no cost increase to our state. Right now, there just aren't incentives for patients to seek care in the proper setting. Just show up in any hospital ER, and by law they have to see you every time—even if you never pay. That's not a sustainable model.

Current EMTALA regulations also compound inadequate Medicaid reimbursement rates even as providers seek to create greater local ownership of issues and cost effective treatment options. In our local county, public and private interests have formed an innovative Health Access Initiative project. The objective of the initiative is to redirect unfunded patients to settings other than the hospital emergency room. This is no magic bullet but it has improved the situation in our region. Although we've seen some limited success, its true potential will not be realized until EMTALA is reconsidered, and enhanced legal protection is afforded providers in the ER setting who are prudently redirecting patients to the proper level of care. At present, Hospitals are precluded from redirecting patients to other more appropriate sources of care, assuming they exist, prior to a screening exam. This exam must include any and all diagnostic tests to complete the screening– so by the time we're done with the evaluation phase, all that remains is the writing of any prescriptions which might be indicated.

Prescription drug costs are another huge irritant to Medicaid cost escalation and ER utilization rates. I can't give this committee an exact number, but can say with confidence many Medicaid and uninsured patients become hospital ER "frequent flyers" because they can't afford to fill their prescriptions. It's simply easier and more practical in the current environment to return to the hospital. Again, fundamental change is required.

Immigration trends in our region and county are also significantly impacting the growth of Medicaid and the cost of caring for the uninsured. In 2003 a local health study, known as "Healthy Hall", found 11% of our popoulation to be uninsured, which in 2005 equates to 18,000 individuals. In the same survey, 33% of Latinos self reported being uninsured. Latinos in our local county are predicted to double from 19% of the population in 2000 to 38% by 2009. Reform of both Medicaid and immigration must be inextricably entwined from my perspective if large hospital providers like Northeast Georgia Medical Center are to survive, especially when financial viability is largely a function of geography, not management talent, or innovative community program development.

Let me explain the implications of our broken system. In relative terms, Northeast Georgia Medical Center is one of the more financially stable hospitals in Georgia, and yet this year we are losing money on operations. Year-to-date, we are running a (negative) –0.2 percent operating margin, and even with investment income our total margin will be less than 3 percent. In the last few years we have seen our total margin steadily deteriorate from 5.1% percent in 2002 to 2.9% percent so far in 2005.

Our hospital also frequently operates at, or beyond, capacity especially in critical high volume Medicaid dependent services like Obstetrics (Where we expect to deliver close to 3,800 babies in 2005 – more than 56% Medicaid). Absent dramatic changes, including significant staff reductions, our health system will not be able to generate the projected $340 million in capital required over the next five years to maintain and expand an aging infrasturcture. This past week my hospital was forced to eliminate 231 full-time jobs and I'm worried that number will only increase over time in the current environment.

In closing, we all share a common interest in affordable healthcare for those in our communities. Medicaid reform is complex, and calls for systemic change that doesn't make an already tenuous situation any worse. I live and breathe the reality of your decisions every day, and have been forced to make some very difficult management choices in the wake of a system that today just does not incentivize rational patient care. At the same time I appreciate the work of the Committee and its Members, and know how seriously you approach the challenge before us. Thank you.